Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

REHAB 2112
200 WYNNEWOOD VILLAGE
DALLAS, TX 75224

Respondent Name
DALLAS NATIONAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 20

MFDR Tracking Number
M4-10-5248-01

MFDR Date Received
AUGUST 23, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Reimbursement for WH is $64.00 per hour. Carrier mistakenly inputted 97546 WHCA as 4 units instead of 5, which what was submitted on the CMS-1500. Carrier failed to process the request for reconsideration. Carrier gave a reference # of 129750123 when I called on 5/27/10 to have bill correctly processed."

Amount in Dispute: $64.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 9, 2009	97546-WH-CA-GP	$64.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific services provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated January 29, 2010
   - W1 – Workers Compensation State Fee Schedule Adjustmen [sic]
   - Z343 – Work hardening
   - Z710 – The charge for this procedure exceeds the fee schedule allowance.

Issues

1. What are the guidelines for the billing of a CARF accredited Work Hardening program?
2. Does the requestor's submitted documentation support the number of units billed? Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.204 (h)((1)(A) states, "If the program is CARF accredited, modifier 'CA' shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR." 28 Texas Administrative Code §134.204(h)(3)(A)&(B) states, "The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier 'WH.' Each additional hour shall be billed using CPT code 97546 with modifier 'WH.' CARF accredited Programs shall add 'CA' as a second modifier ." 28 Texas Administrative Code §134.204(h)(3)(B) states, "Reimbursement shall be $64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes."
2. Review of the requestor's submitted documentation finds a copy of a CMS-1500 for date of service December 1, 2009. The requestor billed four hours and thirty minutes of 1 unit of CPT Code 97545-WH-CA-GP and 5 units of 97546-WH-CA-GP for date of service December 1, 2010. The requestor also submitted a copy of the requestor's work hardening program daily activity notes. The requestor's work hardening daily activity notes only document five hours and fifteen minutes of work hardening activities for date of service December 1, 2009. According to the explanation of benefits dated January 29, 2010, the respondent made payment in the amount of $384.00 to the requestor for a total of six hours of work hardening activities with check number 603750. The documentation submitted by the requestor does not support the total number of units billed for CPT Code 97546 of the work hardening program. Therefore, no additional reimbursement is recommended per 28 Texas Administrative Code §134.204.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		01/31/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.